TIEGERMAN

TEACHING THE EXTRAORDINARY

EXPERTS IN LANGUAGE AND COMMUNICATION DEVELOPMENT

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the parent or guardian:

Student Name: _____DOB _____

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medications; trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

Signature (Parent or Guardian) _____ Date_____

Telephone: Home _____ Work _____

B. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Student _____ DOB _____

Diagnosis: _____

_____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

As per New York State Law, all medication, including Over-the-Counter medication, needs parental and physician authorization to be administered at school. The following standard Over-the-Counter Medications will be available in the Health Office. Only medications that are checked yes and determined to be necessary will be administered at the discretion of a registered nurse. Administration of these medications will be as per label instructions unless otherwise indicated by your physician.

Tylenol (discomfort/fever)	_____ yes	_____ no
Ibuprofen (discomfort/fever)	_____ yes	_____ no
Benadryl (allergies/allergic reaction)	_____ yes	_____ no
Cortisone Ointment (topical for skin irritation)	_____ yes	_____ no
Antibiotic Ointment (topical for cuts, grazes, etc.)	_____ yes	_____ no
Sunscreen	_____ yes	_____ no
Insect Repellant	_____ yes	_____ no

Physician's Signature _____ **Date** _____

Physician's Name _____ Phone _____

Address_____

**Medication must be in original pharmacy labeled container with specific orders and name of medication.*

**Medication and refills must be brought to school by parent, guardian or responsible adult.*

This medication order is valid for one year from date entered above